

**Commission to Study Mental and Behavioral Health
Minutes from September 13, 2022**

1. Introduction

- a. Lt. Governor: Thank everyone for being here. This is the second to last official meeting. One of the things that we're working on is the transition of administrations. I will recommend the next Administration have a similar Mental and Behavioral Health Commission. They should be exploring these issues and how to continue to improve our delivery system for those who are suffering from mental health issues as well as substance use disorder. To continue the efforts to improve our delivery system, we will be passing that information on to them in our final report and the other reports will be available to you as well in terms of the efforts we've made. Moving to the formal agenda as per usual, I'll ask commission members to introduce themselves and we'll start with those who are coming in virtually.

2. Attendance and Minutes Approval

- a. Present: Senator Adelaide Eckardt, Deputy Assistant Secretary Tiffany Rexrode, Lynda Bonieskie, Director Kirsten Robb-McGrath, Barbara Allen, Dr. Lisa Burgess, Patricia Miedusiewski, Dr. Bhaskara Tripuraneni, Cari Cho, Director Robin Rickard, Senator Katie Fry Hester, Associate Commissioner David Cooney, Asst. State Superintendent Mary Gable, Kimberlee Watts, Delegate Karen Lewis Young, Deputy Director Tricia Roddy
- b. Absent: Delegate Ariana Kelly, Richard Abbott, Lt. Col. Roland Butler, Serina Eckwood
- c. Lt. Governor: Minutes will be sent out at a later date.

3. Subcommittee Reports

- a. Crisis Services
 - i. Lisa Burgess: BHA and community stakeholders including Mid-Shore Behavioral Health and the Run of Crisis Intervention team and Affiliated Sante Eastern Shore crisis were invited to present at the Bay Bridge collaborative partnership. The Bay Bridge is one of the largest bridges on the east coast and a site where suicides occur. The Bay Bridge collaborative partnership works to create cross jurisdictional partners and develop a seamless response for people in crisis. DHA participated in a six-state regional collaborative led by the Substance Abuse Mental Health Administration System. The purpose was to showcase crisis system work being completed in each state. The Maryland team had the opportunity to meet with national crisis system experts. To summarize the state of our work underway, They are working to finalize draft regulations for mobile response teams and crisis stabilization centers. The goal is to have the services available through the Medicaid system by July 2023. There are

now 43 designated emergency departments approved to accept emergency petitions. We are now working to develop comprehensive crisis centers which will also be able to accept emergency petitions. Through Child Adolescent and Young Adult Services funding, mobile response and civilization teams are being developed in the Western and Southern regions of Maryland. Lastly, in working with the Parade Foundation and the University of Maryland Institute for Innovation and Implementation, BHA has finalized the crisis assessment tool for adults. We're expecting to train crisis providers on the tool by November of this year. BHA is continuing to work with Medicaid to develop a state plan amendment for mobile response services. This will allow Maryland to access payment through CMS at an enhanced match rate of 85 percent. A rate setting analysis for mobile response teams and crisis stabilization centers is underway. The report with recommendations is expected to be developed by early October. This information will be used to establish the service rates in Maryland. This work has been completed in partnership and feedback from crisis providers. The new three-digit number 988 went live on July 16th in Maryland and across the country. In Maryland, we already had a State-wide crisis center through 211 press one. With the launch of the new 988, we are hearing that the number of calls and texts have increased with some call centers. On September the 20th, a continuous quality improvement work group will be launched for 988. The purpose of the stakeholder work group is to review data and center performance at the 988 call centers. Moving on to the second update, I will discuss the proposed regulations for the dangerousness standard. At the last commission to study Mental Behavioral Health on July 12th, there was a presentation on involuntary commitment and the dangerousness standard in Maryland. Discussed at that time with the proposed regulation changes for the dangerousness standards, which since have been published in the Maryland Register for public comment. On August 12th the proposed COMAR dangerousness standard regulations were published indeed on the Maryland Register for a 30-day public comment and that ended last night at midnight on September the 12th. 90 comments were received from advocates, stakeholders, and constituents. MDH is currently evaluating these comments and we will provide responses to them.

- ii. Lt. Governor: We already have stabilization models on the Eastern Shore, Frederick, Washington, Cecil, and Harford Counties and we're looking to do so in the Western as well as the Southern Counties. The goal is to eventually have every county represented. Thank you, Dr. Burgess.

b. Youth and Families

- i. Kirsten Robb-McGrath: Good evening, Lieutenant Governor, commission members and guests my name is Kirsten Robb-McGrath. I'm the Director of Health and Behavioral Health Policy at the Department of Disabilities. Today, I'm filling in for Deputy Secretary Christian Miele and we'll be reporting out on the Youth and Family Subcommittee. Our Subcommittee

continues to meet on a bi-monthly basis. Last month, we had the privilege of hearing presentations from the National Council on School Mental Health and the Maryland Center for School Safety. I'd like to highlight a few of the initiatives these entities are providing to our youth across the state. The National Council for School Mental Health has many wonderful programs geared towards mental health promotion, prevention and intervention. They have the University of Maryland School of Mental Health program in 22 Baltimore City Tier 1 schools. They host a National Center for School Mental Health Annual Conference, providing insight on the best practices and services and training to educators and providers on well-being, anti-racism, and universal strategies. The Maryland Center for School Safety was established in 2013 to provide coordinated and comprehensive approaches to school safety in Maryland. MCSS develops guidance and training, is developing a nationwide school safety partnership and website of resources, conducts training sessions on school safety and emergency plan reviews, and administers grants to address school safety concerns. In 2018 they launched the Anonymous Reporting System. The system allows students, parents, and community members to anonymously report school or student safety concerns anywhere in Maryland. You can submit a report by calling, visiting their website or using their mobile app. Finally, our subcommittee continues to work on developing our 2022 recommendations. Our subcommittee is interested in pushing forward work focused on increasing access and awareness of advanced mental health directives, expanding youth substance use disorder services along the continuum of care and reviewing service utilization data for youth in the public Behavioral Health System, so we may provide better recommendations on improving the system of care for our youth with behavioral health conditions. Our next meeting is scheduled for October 3rd from 1pm to 3pm via Google Meet. We will be spending most of this meeting finalizing our 2022 recommendations. Thank you.

c. Finance and Funding

- i. Tricia Roddy: Good afternoon, Lieutenant Governor. We've been hosting the system of care integration and optimization work group. That work group consists of Behavioral Health providers and stakeholders as well as the Managed Care organizations. Our real focus, recently, has been on the behavioral health administrative service organization, RFP. We had a couple of meetings where we solicited some comments from the work group members in order to incorporate in the RFP. To talk about the new services that Medicaid is working on, we'll be implementing a mobile crisis service. We are also working on crisis stabilization services. We are working with a consulting firm called Health Management Associates and they have an Actuarial firm working on developing the rates to use the service. They will be developed using a cost-based system with input from providers. Something that Dr. Burgess didn't mention, in the Medicaid

Program, we are going to be covering peer recovery specialists. Those will be limited in the first phase to substance use providers.

- ii. David Cooney: I'll be giving updates on our efforts in the private insurance market. There are two main areas where I have updates today. First is an update on our review of the Mental Health Parity reports from insurance carriers on non-quantitative treatment limitations. These are reports that were required by Senate Bill 334 from 2020. We did mention at the last Commission meeting that we would be issuing orders with stiff penalties for failure to file the reports, timely. Those orders have gone out, the penalties have all been received from the carriers. Two orders for smaller, short-term medical companies. The penalties range from \$30,000 to \$35,000. The third order was sent to the National carrier UnitedHealth Group on behalf of their four companies. Combined, it was a \$100,000 penalty, just for failing to file the reports on time. Since that time, our substantive reviews of reports have been ongoing and there are very strong indicators that we will be very likely to issue more orders for incomplete reports with substantial fines. Before we get to the point of determining whether there's actual parity violations that would require corrective action from the plans and while this is a very tedious review process, we have recently hired an additional contractual employee to assist with the review. That employee will start at the end of this month. Regarding our Network Adequacy Regulations, the latest draft of the revised version of our current regulations was posted on July 7th. The latest developments for this newest draft include more robust documentation requirements for carriers on their processes and efforts to ensure unrolling access to care. There's new data reporting requirements for out-of-network claims and complaints. One of the biggest changes, though, is that there's a new detailed section addressing how Telehealth can support efforts to enhance Network adequacy. This is particularly relevant for Behavioral Health Care. The carriers will be required to report data on Telehealth utilization within their networks. We're currently working through all the comments we've received identifying areas of common concern. After we determine whether to make further revisions, we will be formally proposing the regulations in the Maryland Register in the next few months. The goal is to finalize these regulations close to the beginning of the new year. That concludes the update for the private insurance market

d. Public Safety and Justice System

- iii. Senator Hester: I wanted to start off, Lt. Governor, by saying that I would support your recommendation to continue the commission. We've really focused this past year on following up on the implementation of some of our recommendations for the previous couple years. Our last subcommittee meeting was in August. We heard a presentation from the Governor's Office of Crime Prevention and Victim Services. We also heard a presentation from the National Center on State Courts. The Center of Excellence is moving ahead with a two-day Train the Trainer seminar

on the Sequential Intercept Model. They've already trained 25 individuals, I think last month, and they'll be training another 25 this month. That's getting some of the technical expertise down to the counties' level so they can implement the best practices. They're also planning to hold the Second State Sequential Intercept Model Summit in mid-November, likely the 14th. Secondly, I'm very pleased that the Governor's Office has entered into an agreement with the University of Maryland's Crime Research Innovation Center. What UMD will be able to support them with is developing a strategic plan which is going to look at the outcomes of that State Summit and try to put goals and resources and timelines together. I'm confident they're going to do a really good job. The second presentation that we heard about was from the National Center on State Courts' juvenile SIM efforts, which are currently active in five states. The court system has traditionally been a responsive body as opposed to a proactive body, but we're really interested in pursuing these opportunities and looking at the court adjacent agencies and how they are diverting families away from the criminal justice system and into more appropriate health care services. That was a very interesting presentation. Our next meeting is four Tuesdays from now and I suspect that we will be talking to these University of Maryland Crime Research Innovation Center researchers. They wanted to talk to our committee given our role in The Sim Summit. Thank you.

- iv. Lt. Governor: You had mentioned in the courts' presentation, they mentioned that five states are looking at Juvenile Court diversion. Is that what it is that those five states are doing?
- v. Senator Hester: That is what they're doing, yes. They're looking at the entire Sequential Intercept Model and the Court's role in that specifically with respect to trying to prevent the youth from entering the Criminal Justice System.
- vi. Barbara Allen: Katie, when you're talking about juveniles and diversion, is this in any way like our LEAD Program?
- vii. Kimberly Watts: I don't believe so. When we talk about diversion for juveniles typically, we're talking about the school systems, we're talking about the Department of Juvenile Services. They do quite a lot of diversion particularly under the new statutes that say they essentially, for most crimes, can't charge children under 13. DJS does a lot of intakes, but then they refer them to appropriate services. It's not quite as informal as the lead program at least as I understand that program, okay thank you sure, okay thank you, no
- viii. Lt. Governor: In our last meeting, we talked about the Behavioral Health Administration presenting a proposal on enhancing the Maryland Danger Standard to self and others, we also heard public testimony for additional proposals or amendments to the proposed regulations. They included making specific imminence not a requirement for intervention, explicitly including the ability to include a person's treatment, a behavioral history and pattern of assessing whether the full picture of the person's

circumstances point to a need for intervention, make explicit damage to a person's brain, continued psychosis or ongoing psychiatric deterioration as a form of harmfulness to self. We sent out a survey to our commission members polling the preferences on these amendments and we will be sending a letter expressing the commitment based on the regulation. The survey asked if you support all three, one or more of the three, or none of these potential amendments. Most responses came back supporting all three amendments, there was a plurality of support for two of the three, two individuals said none of the above and then two individuals supported just one. We know that the comment period ended today; what I plan to do is send a letter out from the Commission expressing the consensus of the Commission and give the secretary an opportunity to come and update the commission at some point on the rulemaking process in our last meeting.

4. Public Testimony

- i. Lt. Governor: At this point we'll turn to public testimony.
- ii. Joanne Oport: Hi everyone, my name is Joanne Oport. I am a Kenyan by birth, but I live in Maryland. I'm a citizen of the United States. I'm here in my capacity as a CEO and co-founder of Africans for Mental Health, but I'm also a commissioner. I serve on the commission on African Affairs, and I chair the Workforce Development and education subcommittee. In relation to Mental Health, I hope in the language that is being proposed that there is language that supports caregivers in particular, parents' siblings who have been there to provide care for their loved one who's living with mental illness. There are great mishaps during the process of when they come in to take your loved one to get care, the questions being asked legitimately to those caregivers are; what's going on, what did you observe, what did you see, what do you think, etc. But then once the patient has been admitted, there's a complete dismissal of caregivers in that conversation. While medical professionals are caregivers, once you've already taken care of that patient, that patient is released and discharged to go back home. The people who probably take care of that person are the loved ones who are with them all the time. I hope that language is inclusive of that, in ensuring that the voices of those caregivers who are not medically trained but have been observing that consumers going through crisis over time are heard. For us, as the Immigrant Community, there's a misstep in the level of care we receive. I've seen where and I've gotten reports as Africans for Mental Health, that patients stayed longer when you're an immigrant. The stabilization process is much longer for an immigrant person than it is for a non-immigrant. Maybe in the checks of analysis for standard of care, that is also observed, and that is also taken care of.
- iii. Lt. Governor: Do you think that's a cultural gap?
- iv. Joanne Oport: It could be. I'm not a medically trained professional, I've just been observing this for over 10 years. The longer you leave that person, the harder it is for them to recover. I think that costs more money rather than just addressing the situation quickly. Once a patient has already

been discharged, the social services follow-up is not sustainable. It's not effective and in most cases, that's why patients come back.

- v. Kimberlee Watts: Quick follow-up question, are there sufficient interpreters? I'm assuming that not everyone who's an immigrant speaks English and is that part of the problem.
- vi. Joanne Oport: Perhaps with the length of stay, otherwise no. There's no sufficient system and sometimes they use the providers who are already on site. Let's say you hired a Nigerian or a Kenyan who speaks another language, then you want to utilize them as a translator as well as the care provider. The separation and types of impartiality is not there. If I'm your nurse and I'm the same one who's translating for the doctor, then are you really addressing the patient? Is there really a patient advocate in that conversation piece? Are you really saying the things that are in line with the care or are you more likely to follow the institution that you work with?
- vii. Lt. Governor: The caregiver point that you made at first is a real challenge. A lot of that is the federal process and it flows down to the state. For an adult who is 18 years old or older, who is in crisis, they're pretty much deemed to be competent to make their health care decisions. Their information is private to them unless they allow someone else to know so that's why the doctors will stop telling you what the diagnosis is and that is a real problem.
- viii. Joanne Oport: The last piece I want to add is when a patient is getting care and they come from out of state and they have a provider from out of state, I've seen where the doctors who are taking care of that particular patient, don't want to talk to, for example, the out-of-state provider who's been a care provider for that particular patient and I feel like that's a great disservice. If someone has been committed to going to a hospital or seeing a mental health provider, I understand this HIPAA regulation but there should be some type of relationship where at the end of the day the patient's wellness is at the forefront. How do we make sure we mitigate them falling deeper into crisis?
- ix. Cari Cho: The other thing that you spoke to that I want to comment on because it's a huge deal, is the issue that when people leave, they get through a crisis, but then where do they go? The follow-up care isn't there and that's one of the concerns. It's wonderful, it's great, that you know we're focusing on crisis services and trying to beef that up, but we also must look at what resources are available and where. And the lack of qualified psychiatrists only adds to that problem.
- x. Lt. Governor: Several years ago, there was a talk about this demographic bubble, that the baby boomers were retired. There was this large percentage of people that would be eligible to retire within the next 10 years. Now we're beyond that 10-year period. I think part of all this, you look at teachers, you look at therapists, you look at others, many of them that are not returning are at retirement age. Then there are others who just have other reasons, they can do something different, whatever. Part of this

was kind of inevitable, yes, but then let's throw in the fact that COVID has exacerbated a problem that was already out there. The positive side is increased awareness for mental health issues, but it brought a lot of issues out of the woodwork. People who were maybe dealing with mental health issues, but weren't diagnosed, now are really having problems. They're not quite functional and so they're showing up at your doorstep. We're not feeding the pipeline either, I think in terms of schools. Dr. Tripuraneni talked about the lack of psychiatrists.

- xi. Senator Eckardt: The other issue is that caregivers and nurses and other professionals who are working in our facilities are having to do double and triple shifts. I know even in our nursing homes it is terrible out there and we have folks who are just quitting because they're so compromised with knowing that they're not able to provide the care that they've been educated and prepared to provide. I think we have a tsunami and I've been trying to figure out how we can use some of the creative apprentice and workforce incentives in the business community. I'm concerned we're going to have a collapse of a whole system at the rate we're going. We've been debating putting together a psychiatric nursing program that would be for all types of caregivers through the Community Colleges, so that could help.
- xii. Lt. Governor: Tell me about that nursing program you just mentioned please.
- xiii. Senator Eckardt: Within the Department of Health, they are working on putting that together.
- xiv. Senator Hester: I believe there is a commission to study the shortage across the entire HealthCare industry and they're probably due for a report in December. There are two or three scholarship and loan repayment options. There are a lot of bills that come to the Education Health and Environmental Committee, I would be happy to circulate the three or four that I'm involved with.
- xv. Lt. Governor: Particularly, if we passed the scholarship bills, that would be information that we should make sure we get out.
- xvi. Senator Eckardt: It's out there, and we could certainly get that and share that information with this group because I think that will be helpful.
- xvii. Lt. Governor: Okay well we had another come in, Evelyn Burton.
- xviii. Evelyn Burton: Thank you. I haven't gotten all my final counts yet, but we know that at least 88 of the comments that were sent in were sent in by family members, so obviously there's a big need for this change. I sent comments as well which included the three recommendations you spoke about. In addition, I was sort of concerned that when the actual final regulations were published, it only included one section of regulations, that specifically related to the filling out of certifications for involuntary hospital admission. Yet, the danger standard, or the same exact words, appear in at least five other places in the statute. My concern is, since it's only in this one narrow part of the regulations, that the other people who are responsible for carrying out the law in these other areas like the police

who did petitions and even the judges who do the hearings, are they going to feel that that definition applies to their roles? I suggested that it could be solved in one of two ways. It could be put in the general definition section to apply to the whole article, or it could be put as regulations that apply to each of those sections. That was my initial concern with doing regulations. Will all these people even look at health regulation if it's not in statute? That's something the commission might want to think about when you send in your comments.

xix. Lt. Governor: Did you put that in your comments?

xx. Evelyn Burton: Yes, I did. I'll send a copy of my comments to the commission. The other thing that I was a little concerned about is that the language was changed a little bit from what it was first presented to the commission at the last meeting. They added in the language that "should an individual experience an incident that..." and then it listed all the standards and there was never a previous mention of the incident. I'm a little concerned with the use of that word because it implies an action that has recently happened, whereas a lot of disability and dangerous self, is basically what you would consider passive action. If somebody is slowly deteriorating and not eating much and it's been a gradual process, is that considered an incident? I don't know. So, I think the use of that word is a little confusing and I don't think it needs to be in there at all. If it is, we suggest adding after that or exhibit active or passive behavior, so that it wouldn't be just considered an act, like threatening someone or a singular event. It was important what condition the person is in, not a single moment or incident that happened. Other than that, I'm certainly pleased that they're looking at improving it a lot and I think it will help get a lot of people into care that right now can't get into care. It will reduce some of the barriers. Without the three recommendations that your commission looked at, there's going to be a lot of people that there will still be barriers for because they're not at the point yet where their mental condition has created physical condition which is basically what the Department's interpretation of the Grave Disability Standard says. I look forward to the Commission's recommendations. I hope those will be posted on your website. Another question, the 23-hour Evaluation Center, if they feel that they need to have an involuntary hospitalization and there's no bed available, would they then be transferred to an emergency room to be held there until there's a bed available?

xxi. Dr. Tripuraneni: Yes, you cannot keep a patient past 23 hours

xxii. Evelyn Burton: Thank you. I will say, I've had some experience with Arizona, I was amazed that they have such an incredible support system for people with serious mental illness. Anyone there who's diagnosed with a serious mental illness is automatically given a case manager no matter what insurance or lack of insurance they have, and they're automatically assigned to a clinic where they can get prescribed medication. They take care of people

- xxiii. Barbara Allen: Well Evelyn, they've also had 20 plus years of working on the system which is great.
- xxiv. Evelyn Burton: I heard there was also, 10 years ago, a lawsuit against the state that they were not providing services to people and a judge ordered a lot of the system to be put in place. It's a shame that it must come to that. Thank you everyone.

5. Conclusion

- i. Lt. Governor: We have one more meeting, but we are going to recommend that the next Administration continue this effort. However they would like to formulate a commission, my recommendation would be to stay to a number like ours or less. We will have another meeting in November and at that point we will draft the final report with recommendations to which we will present to the incoming Governor. The idea, though, would be presenting it to the next Governor in terms of recommendations of what they should do going forward. We'll see what the danger standard looks like in terms of the proposal. I might venture to say I'd like to see us recommend that there be legislation to codify some of the danger standards. With that said, thank you again everybody and we will see you next time.